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Date

2/13/01

Number of pages

22 (including cover page)

to:

Name

U.S. Patent Office

Company

P.T.O.

Telephone

703 305 9285

Fax

703 308 6916

from:

Name

Patrizia Smith

Company

2901 Beverly Blvd

Telephone

LA CA 90057

Fax

Comments

FAX RECEIVED

FEB 13 2001

PETITIONS OFFICE

WASHINGTON FERRY


PATRICK SMITH
2901 BEVERLY BLVD
LOS ANGELES, CA 90057

193


DATE February 12, 2001 15-66/1220 99

PAY TO THE ORDER OF Assistant Commissioner for Patents \$1,125.00

One thousand one hundred twenty five and no/100 ----- DOLLARS

 Bank of America
Westwood Village Branch #0288
930 Westwood Boulevard
Los Angeles, CA 90024 (310) 247-3660

for patent # 5,598,947



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FEB 13 2001

PETITIONS OFFICE

Petition Section
Patent # 5,598,947
Patrick Smith

Please type a plus sign (+) inside this box ☐

PTO/SB/45 (01-01)
 Approved for use through 12/31/2002. OMB 0651-0016
 U.S. Patent and Trademark Office; U.S. DEPARTMENT OF COMMERCE

Under the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

MAINTENANCE FEE TRANSMITTAL FORM

Address to:
 Assistant Commissioner for Patents
 Box M Fee
 Washington, D.C. 20231

I hereby certify that this correspondence is being deposited with the United States Postal Service with sufficient postage as first class mail in an envelope addressed to "Assistant Commissioner for Patents, Box M Fee, Washington D.C. 20231" on February 12, 2001

Signature _____

Typed or printed name Patrick Smith patentee

Enclosed herewith is the payment of the maintenance fee(s) for the listed patent(s).

- ☒ A check for the amount of \$ 1,125.00 for the full payment of the maintenance fee(s) and any necessary surcharge on the following patents is enclosed.
- ☐ The Commissioner is hereby authorized to charge \$ _____ to cover the payment of the fee(s) indicated below to Deposit Account No. _____.
- ☐ The Commissioner is hereby authorized to charge any deficiency in the payment of the required fee(s) or credit any overpayment to Deposit Account No. _____.
- ☐ Payment by credit card. Form PTO-2038 is attached.

*Information required by 37 CFR 1.366(c) (columns 1 & 4). Information requested under 37 CFR 1.366(d) (columns 2, 3, 5, & 6)

Item	Patent Number 1	Maintenance Fee Amount (37 CFR 1.20 (e)-(g)) 2	Surcharge Amount (37 CFR 1.20 (h)-(i)) 3	U.S. Application Number* (06/555,555) 4	Payment Year 5			Small Entity? 6
					3.5 yrs	7.5 yrs	11.5 yrs	
1	5,598,947	\$425.00	\$700.00		X			X
2								
3								
4								
5								
6								

Subtotals Columns 2 & 3

Total Payment

☐ _____ additional sheets attached for listing additional patents.

WARNING: Information on this form may become public. Credit card information should not be included on this form. Provide credit card information and authorization on PTO-2038.

Respectfully submitted***:

Customer's name: Patrick SmithTelephone: no phone

Fax:

Customer's Signature: Patrick Smith

Note. *All correspondence will be forwarded to the "Fee Address" or to the "Correspondence Address" if no "Fee Address" has been provided. 37 CFR 1.363.

**Payment of small entity fee is appropriate if small entity status still exists, see 37 CFR 1.27(g). To establish small entity status or to change status from small to large entity, note the requirements of 37 CFR 1.27 and 1.33(b).

***WHERE MAINTENANCE FEE PAYMENTS ARE TO BE MADE BY AUTHORIZATION TO CHARGE A DEPOSIT ACCOUNT, BOTH CUSTOMER'S NAME AND SIGNATURE ARE REQUIRED.

Burden Hour Statement: This collection of information is required by 37 CFR 1.366. This information is used by the public to submit (and by the USPTO to process) payment of patent maintenance fees. Confidentiality is governed by 35 U.S.C. 122 and 37 CFR 1.14. This collection is estimated to take 0.08 hours to complete, including gathering, preparing, and submitting the complete payment of maintenance fees. Time will vary depending on the individual case. Any comments on the amount of time you require to complete this form and/or suggestions for reducing this burden should be sent to the Chief Information Officer, U.S. Patent and Trademark Office, U.S. Department of Commerce, Washington, DC 20231. DO NOT SEND FEES OR COMPLETED FORMS TO THIS ADDRESS. SEND TO: Assistant Commissioner for Patents, Washington, DC 20231.

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PETITIONS OFFICE

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#19

PTO/SB/55 (10-00)

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PETITIONS OFFICE

**PETITION TO ACCEPT UNAVOIDABLY DELAYED PAYMENT OF
 MAINTENANCE FEE IN AN EXPIRED PATENT (37 CFR 1.378(b))**

Docket Number (Optional)

Mail to: Assistant Commissioner for Patents
 Box DAC
 Washington, D.C. 20231

NOTE: If information or assistance is needed in completing this form, please contact Petitions Information
 at (703) 305-9282.

Patent No. 5,598,947 Application Number 08/377,449
 Issue Date Feb 4, 1997 Filing Date _____

CAUTION: Maintenance fee (and surcharge, if any) payment must correctly identify: (1) the patent
 number (or reissue patent number, if a reissue) and (2) the application number of the
 actual U.S. application (or reissue application) leading to issuance of that patent to
 ensure the fee(s) is/are associated with the correct patent. 37 CFR 1.366 (c) and (d).

Also complete the following information, if applicable

The above-identified patent:

- ☐ is a reissue of original Patent No. _____, original issue date _____;
 original application number _____,
 original filing date _____.
- ☐ resulted from the entry into the U.S. under 35 U.S.C. 371 of international
 application _____ filed on _____.

CERTIFICATE OF MAILING (37 CFR 1.8(a))

I hereby certify that this paper (along with any paper referred to as being attached or enclosed) is
 being deposited with the United States Postal Service on the date shown below with sufficient
 postage as first class mail in an envelope addressed to the Assistant Commissioner for Patents,
 Box DAC, Washington, D.C. 20231.

Feb 12, 2001

Date


 Signature

Patrick Smith patentee

Typed or printed name of person signing Certificate

[Page 1 of 4]

Burden Hour Statement: This collection of information is required by 37 CFR 1.378. This information is used by the public to submit (and by the U.S. PTO to process) payment of patent maintenance fees. Confidentiality is governed by 35 U.S.C. 122 and 37 CFR 1.14. This collection is estimated to take 1.0 hour to complete, including gathering, preparing, and submitting the complete payment of maintenance fees. Time will vary depending on the individual case. Any comments on the amount of time you require to complete this form and/or suggestions for reducing this burden should be sent to the Chief Information Officer, U.S. Patent and Trademark Office, U.S. Department of Commerce, Washington, DC 20231. DO NOT SEND FEES OR COMPLETED FORMS TO THIS ADDRESS. SEND TO: Assistant Commissioner for Patents, Washington, DC 20231.

PTO/SB/65 (10-00)

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1. SMALL ENTITY

☒ Patentee claims, or has previously claimed, small entity status. See 37 CFR 1.27.

2. LOSS OF ENTITLEMENT TO SMALL ENTITY STATUS

☐ Patentee is no longer entitled to small entity status. See 37 CFR 1.27(g).

3. MAINTENANCE FEE (37 CFR 1.20(e)-(g))

The appropriate maintenance fee must be submitted with this petition, unless it was paid earlier.

NOT Small Entity			Small Entity		
Amount	Fee	(Code)	Amount	Fee	(Code)
<input type="checkbox"/> \$ _____	3 1/2 yr fee	(183)	<input type="checkbox"/> \$ _____	3 1/2 yr fee	(283)
<input type="checkbox"/> \$ _____	7 1/2 yr fee	(184)	<input type="checkbox"/> \$ _____	7 1/2 yr fee	(284)
<input type="checkbox"/> \$ _____	11 1/2 yr fee	(185)	<input type="checkbox"/> \$ _____	11 1/2 yr fee	(285)

\$425.

\$700.

\$1,125

MAINTENANCE FEE BEING SUBMITTED \$ _____

4. SURCHARGE

The surcharge required by 37 CFR 1.20(i)(1) of \$ _____ (Fee Code 187) must be paid as a condition of accepting unavoidably delayed payment of the maintenance fee.

\$700. ?

SURCHARGE BEING SUBMITTED \$ _____

5. MANNER OF PAYMENT

- ☐ Enclosed is a check for the sum of \$ 1,125.00
- ☐ Please charge Deposit Account No. _____ the sum of \$ _____. A duplicate copy of this authorization is attached.
- ☐ Payment by credit card. Form PTO-2038 is attached.

6. AUTHORIZATION TO CHARGE ANY FEE DEFICIENCY

- ☐ The Commissioner is hereby authorized to charge any maintenance fee, surcharge or petition fee deficiency to Deposit Account No. _____. A duplicate copy of this authorization is attached.

[Page 2 of 4]

I was told to pay \$425. plus \$700. for unavoidably delayed payment of maintenance fee.

PTO/SB/65 (10-00)

Approved for use through 12/31/2002. OMB 0651-0016

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7. OVERPAYMENT

As to any overpayment made please

OR

☐ Credit to Deposit Account No. _____☐ Send refund check.

WARNING: Information on this form may become public. Credit card information should not be included on this form. Provide credit card information and authorization on PTO-2038.

8. SHOWING

The enclosed statement will show that the delay in timely payment of the maintenance fee was unavoidable since reasonable care was taken to ensure that the maintenance fee would be paid timely and that this petition is being filed promptly after the patentee was notified of, or otherwise became aware of, the expiration of the patent. The statement must enumerate the steps taken to ensure timely payment of the maintenance fee, the date and the manner in which the patentee became aware of the expiration of the patent, and the steps taken to file the petition promptly.

9. PETITIONER(S) REQUESTS THAT THE DELAYED PAYMENT OF THE MAINTENANCE FEE BE ACCEPTED AND THE PATENT REINSTATED.

Feb 12, 2001

Date

(_____)

Telephone Number
no phone
Signature(s) of Petitioner(s)Patrick Smith

Typed or printed name(s)

2901 Beverly Blvd.

Address

Los Angeles, CA 90057

ENCLOSURES:

- ☒ Maintenance Fee payment
☐ Statement why maintenance fee was not paid timely
☒ Surcharge
☐ _____

PTO/SB/65 (10-00)

Approved for use through 12/31/2002. OMB 0651-0016

U.S. Patent and Trademark Office; U.S. DEPARTMENT OF COMMERCE

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37 CFR 1.378(d) states: "Any petition under this section must be signed by an attorney or agent registered to practice before the Patent and Trademark Office, or by the patentee, the assignee, or other party in interest."

Feb 12, 2001

Date



Signature

Patrick Smith patentee

Typed or printed name

STATEMENT

(In the space below, please provide the showing of unavoidable delay recited in paragraph 8 above.)

The delay in timely payment of the maintenance fee was unavoidably because I was injured in an accident and lost the vision in my left eye due to a blow to the head. My loss of vision was determined to be due to a vascular problem, hemorrhage in the eye, or to a neurological problem, compressed nerve. (see enclosed sample of medical reports)

During the time since the accident and continuing up to now I suffer from Vertigo and fail to properly focus or concentrate due to sense of unbalance continually. I failed due to my injury to act in a timely manner, finally realizing the need to do so today. I called the Patent Office and was told what to do.

Sincerely,



Patrick Smith

(Please attach additional sheets if additional space is necessary)

10720 N. J. 124
PATIENT INFORMATION SHEETPLEASE COMPLETE FORM
PRINT

ARRIVAL TIME: 11:35

PLEASE NOTE: PATIENTS ARE SEEN ACCORDING TO THE SEVERITY OF THEIR COMPLAINT AND NOT NECESSARILY IN THE ORDER IN WHICH THEY SIGNED IN. THIS DECISION WILL BE MADE BY THE NURSE. THANK YOU FOR YOUR UNDERSTANDING.

PATIENT NAME

SMITH	PATRICK	MI
LAST	FIRST	MI

JUNE 20, 1934	65	Male
BIRTHDATE	AGE	SEX

487 34 0635
SOCIAL SECURITY NUMBER

Hit in head in auto accident
REASON YOU ARE HERE TODAY

None	MD PHONE #
PRIVATE DOCTOR	

No Private Doctor



Clinic Patient



ARE YOU TAKING ANY MEDICATIONS? YES ☐ NO ☒
If yes, please list (prescription and non-prescription)

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ☐ NO ☒
If yes, please list

Aspirin



Penicillin



Sulfa



Other:

SMITH, PATRICK

Wed Aug 09, 2000

Page 1
11:18 AM

Discharge Instructions from S. LEVINE, MD
Saint John's Hospital and Health Center Emergency Department

C/9/00
FAX RECEIVED

FEB 13 2001

DIZZINESS:

Dizziness is a common problem that has many causes. Most illnesses and many medications can cause dizziness along with other symptoms. It may at times signal a problem with the heart or circulation. Even many minor diseases, such as viral infections, often have dizziness as one of the main symptoms.

PETITIONS OFFICE

Vertigo is a kind of dizziness that gives the sensation that you or your surroundings are spinning. This usually involves the balance centers in the inner ear - and is often caused by a virus infection. In the elderly, poor circulation to the brain will often cause vertigo.

The actual cause of an episode of dizziness is often very hard to pinpoint. Your evaluation today indicates that a serious cause is not likely. You should remain at rest until you are feeling better. If your symptoms persist or worsen, or if other symptoms develop, you will need follow-up with your doctor or the Emergency Department.

NOTIFY YOUR DOCTOR or return here in case of the following:

- Dizziness is worsening or any fainting.
- Chest pain or discomfort of any kind, or irregular heartbeat.
- Abdominal or back pain that is worsening or changing in location.
- Prolonged or high fever.
- Severe or worsening headache.
- Change in mental status - too sleepy, confused, short of breath, irritable, slurred speech, weakness, or difficulty walking.
- Repeated vomiting or inability to retain fluids.

OTHER INSTRUCTIONS:

YOU WERE EVALUATED IN THE EMERGENCY ROOM FOR DIZZINESS BY DR. S. LEVINE, THE CARDIOLOGIST. FOLLOW UP WITH HIM AT HIS OFFICE TOMORROW AS DIRECTED. RETURN SOONER TO THE ER FOR ANY CHANGE IN OR WORSENING OF SYMPTOMS

If you have more questions or problems with your medical condition or the treatment, see your doctor or call us at number (310) 829-8212.

My signature indicates that I understand, and have received a copy of, the above instructions.

034/195-39-54 3
SMITH, PATRICK
M 66 06/20/1934
08/30/00 ODOPC

VN# 3023

SML

195-39-54 3023 2

FAX RECEIVED

FEB 13 2001

PETITIONS OFFICE

(Medical)

UCLA HOSPITAL & CLINICS CONSULTATION REQUEST		
PATIENT'S FLOOR	PATIENT'S ROOM	SERVICE
REQUESTING PHYSICIAN <i>Lynn Gordon</i>		
REQUESTING PHYSICIAN'S TELEPHONE NUMBER <i>page 09701</i>		
NAME OF CONSULTING PHYSICIAN REQUESTED <i>WY Neurology clinic</i>		
PHYSICIAN REQUIRED IS: <input type="checkbox"/> ATTENDING PRIVATE <input type="checkbox"/> PERSONAL PRIVATE		
DATE OF CONSULTATION REQUEST <i>8/30/00</i>		CONSULTATION RE BY THIS DATE <i>ASAP</i>

INTERNAL MEDICINE	PEDIATRICS	SURGERY	OTHER SPECIALTIES
<input type="checkbox"/> GENERAL MEDICINE <input type="checkbox"/> CARDIOLOGY <input type="checkbox"/> CLIN. IMMUNOLOGY-ALLERGY <input type="checkbox"/> CLIN. PHARMACOLOGY <input type="checkbox"/> DERMATOLOGY <input type="checkbox"/> ENDOCRINOLOGY-METABOLISM <input type="checkbox"/> GASTROENTEROLOGY <input type="checkbox"/> GENETICS <input type="checkbox"/> HEMATOLOGY-ONCOLOGY <input type="checkbox"/> INFECTIOUS DISEASE <input type="checkbox"/> NEPHROLOGY-HYPERTENSION <input type="checkbox"/> PULMONARY <input type="checkbox"/> REHABILITATION MEDICINE <input type="checkbox"/> RHEUMATOLOGY-ARTHRITIS <input type="checkbox"/> _____	<input type="checkbox"/> GENERAL PEDIATRICS <input type="checkbox"/> PEDIATRIC CARDIOLOGY <input type="checkbox"/> PEDIATRIC ENDOCRINOLOGY <input type="checkbox"/> PEDIATRIC GASTROENTEROLOGY <input type="checkbox"/> PEDIATRIC GENETICS <input type="checkbox"/> PEDIATRIC HEMATOLOGY <input type="checkbox"/> PEDIATRIC IMMUNOLOGY <input type="checkbox"/> PEDIATRIC INFECTIOUS DISEASE <input type="checkbox"/> PEDIATRIC NEPHROLOGY <input type="checkbox"/> PEDIATRIC NEUROLOGY <input type="checkbox"/> CHILD DEVELOPMENT <input type="checkbox"/> _____	<input type="checkbox"/> GENERAL SURGERY <input type="checkbox"/> GEN. VASCULAR & PED. SURGERY <input type="checkbox"/> GEN. & ABDOMINAL SURGERY <input type="checkbox"/> ONCOLOGICAL SURGERY <input type="checkbox"/> HEAD & NECK (OTOLARYNGOLOGY) <input type="checkbox"/> NEUROSURGERY <input type="checkbox"/> ORAL & MAXILLOFACIAL SURGERY <input type="checkbox"/> ORTHOPEDICS <input type="checkbox"/> PLASTIC SURGERY <input type="checkbox"/> THORACIC SURGERY <input type="checkbox"/> UROLOGY <input type="checkbox"/> _____	<input type="checkbox"/> ANESTHESIA <input type="checkbox"/> AUDIOLOGY & SPEECH <input type="checkbox"/> DENTISTRY-INPATIENT <input type="checkbox"/> DENTISTRY-OUTPATIENT <input checked="" type="checkbox"/> NEUROLOGY <input type="checkbox"/> OB/GYN <input type="checkbox"/> OCCUPATIONAL THERAPY <i>(use their request form no.)</i> <input type="checkbox"/> OPHTHALMOLOGY <input type="checkbox"/> PATHOLOGY <input type="checkbox"/> PHYSICAL THERAPY <i>(use their request form no.)</i> <input type="checkbox"/> PSYCHIATRY (CALL 502) <input type="checkbox"/> PROSTHETICS <input type="checkbox"/> RADIOLOGY-DIAGNOSTIC <input type="checkbox"/> RADIOLOGY-NUCLEAR <input type="checkbox"/> RADIOLOGY-THER (CALL) <input type="checkbox"/> SOCIAL SERVICE

THIS CONSULTATION IS ☐ ROUTINE ☐ URGENTSTATE THE PROBLEM: *66 yo M slip left supraorbital trauma.*

*in accident 40 dizziness 1 episode LOC → UCLA ER
pt signed out AMA. Pt requested to have MRI
not done, continues to have dizziness.*

*in codes since
ER and long
put on the monitor*

Appt:

*10/24/00, Tues 3
DR DOMINICK*

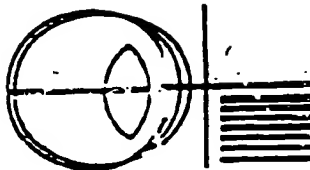
SEND REQUEST TO HOUSE STAFF

PHONE APPROPRIATE NUMBER

195-39-54 3
 PATRICK
 06/20/1934
 08/30/00 ODOPC
 195-39-54 3023 2

VN# 3023

SML



UNIVERSITY OPHTHALMOLOGICAL
 ASSOCIATES

JULES STEIN EYE INSTITUTE

100 Stein Plaza, UCLA

First Floor

Box 957000

Los Angeles, CA 90095-7000

(310) 825-3090

Follow-up Examination

FAX RECEIVED

OT
 Patient Name:

FEB 13 2001

Date: 8-30-00

Age and Sex: 66 yom

PETITIONS OFFICE

Date of Prior Examination: 9-17-99

INTERVAL HISTORY:

S/P KPE/PCUOL, OD

Pt was involved in a car accident
 last 12/11/99 & lost vision in OS
 car door struck by 2nd vehicle
 and door slammed back on OS

(L) Orbit - bruising above superior orbital ridge

VISUAL ACUITY:

20/60
 RE PH
 LE CLE 6" PH

lost VA OS immediately
 ditzig - cedars since
 told of probable compressed nerve

Near Di. 18/20-25
 cc

Medications:

gts.
 NKDA

Alancolone - 300
 2x

WEARING PRESCRIPTION:

RE
 LE

REFRACTION:

Manifest:

Dist: Add: Near:
 RE -1.00 VA 20/20-25 +2.50 VA 20/20
 LE Balance VA 20/20 VA 20/20

Over-Refraction:

+0.50 PL 20/20
 RE VA 20/20
 LE VA 20/20

1 month ago -> LOC in pharynx
 Cycloplegic: taken to ER at
 left ER AMA

RE VA
 LE VA

VERBATOMETRY: fko Cedars -
 ER NO MRI or CT

RE NO MRI or CT
 LE Since acci.

SLIT LAMP EXAMINATION

RE

LE

Eyelids/lashes

Conjunctive

Cornea

Anterior Chamber

Iris

Lens

- ☐ normal OU
- ☐ clear OU
- ☐ clear OU
- ☐ deep & quiet O
- ☐ normal OU
- ☐ clear OU

INTRAOCULAR PRESSURE: Applanation Pneumotonometer Tono

RE 12 mm Hg LE 14 mm Hg Time 9:55 A

P.IOL

2+ NS
 1+ vitreal
 p.c. OS

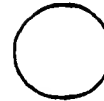
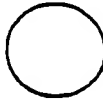
DILATED EXAMINATION: (Agent: M1 M^{1/2} C1 C^{1/2} CM N2.5 N10 A1)

Time: 10:35

Optic Nerve Heads

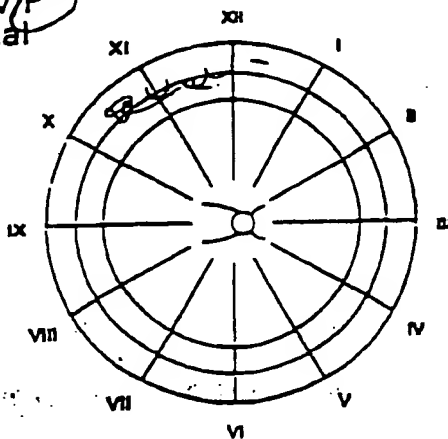
RE

LE

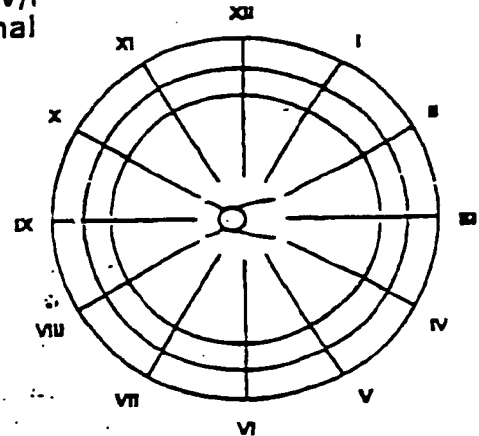


cup/disc 

☒ D/MN/P
normal



☒ D/MN/P
normal



IMPRESSION:

ATTENDING:

A/s/p trauma - request VF

① ? poss to RAPD but doubt

② cataract if VF OK
consider CE

③ dizzy - refer to neurology

RECOMMENDATIONS:

PHYSICIANS CONTACTED:

☐

Letter

☐

Telephone

Follow-up:

Signature: Gord

Supervising Faculty: _____

Single Field Analysis

Eye: Right

Name: SMITH, PATRICK

ID: 1953554

DOB: 06-25-1934

Central 30-2 Threshold Test

Fixation Monitor: Blindspot

Fixation Target: Central

Fixation Losses: 8/19

False POS Errors: 1 %

False NEG Errors: 0 %

Test Duration: 08:17

Fovea: 33 dB

Stimulus: III, White

Background: 31.5 ASE

Strategy: SITA-Standard

Pupil Diameter:

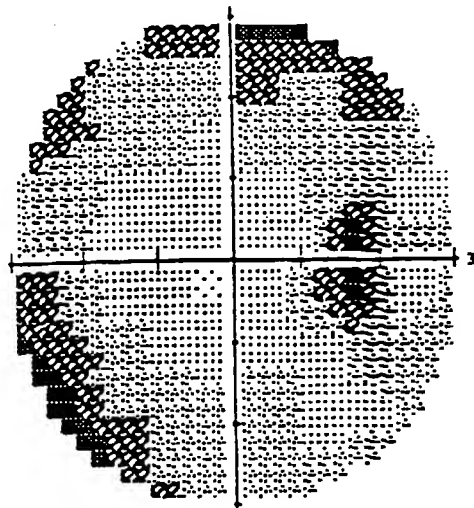
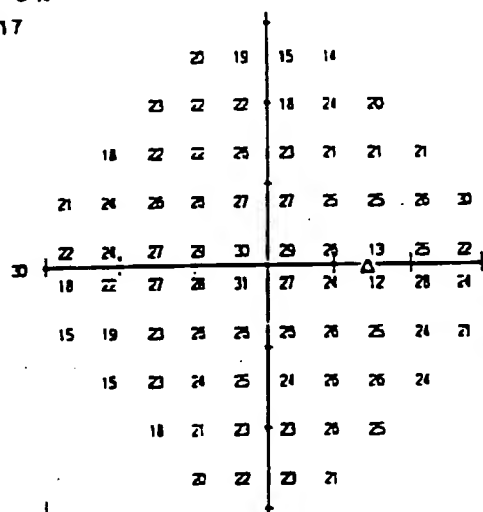
Visual Acuity:

RX: +2.25 DS DC X

Date: 09-01-2000

Time: 2:39 PM

Age: 66



		-3	-4		-9	-9		
		-3	-4	-4	-9	-2	-5	
		-8	-6	-6	-3	-6	-7	-7
-5	-4	-4	-5	-4	-4	-5	-4	-2
-4	-5	-3	-3	-2	-3	-5	-4	-6
-8	-8	-4	-4	-2	-5	-7	-1	-4
-10	-9	-7	-6	-6	-5	-5	-5	-6
	-12	-6	-7	-6	-7	-4	-4	-5
		-10	-8	-6	-6	-3	-4	
			-7	-5	-5	-7		

Total

Deviation

::	::	::	::	::	::	::	::	::	::
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Pattern

Deviation

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GHT

General Reduction of Sensitivity

MD -5.04 dB P < 0.5%

PSD 2.42 dB P < 10%

:: < 5%

□ < 2%

■ < 1%

■ < 0.5%

JULES STEIN EYE INSTITUTE / U.C.L.A.
 GLAUCOMA DIVISION, 2ND FLOOR
 VISUAL FIELD LAB. ROOM 2
 100 STEIN PLAZA, L.A. CA 90095
 310-794-9442 FAX 310-794-5541.

Field Analysis

Eye Left

Re: SMITH, PATRICK

ID: 1953554

DOB: 06-20-1924

Humphrey 30-2 Threshold Test

Fixation Monitor: Blindspot

Stimulus: III, White

Pupil Diameter:

Date: 09-01-2000

Fixation Target: Central

Background: 31.5 ASB

Visual Acuity:

Time: 2:51 PM

Fixation Losses: 0/15

Strategy: SITA-Standard

RX: +2.75 DS 00 X

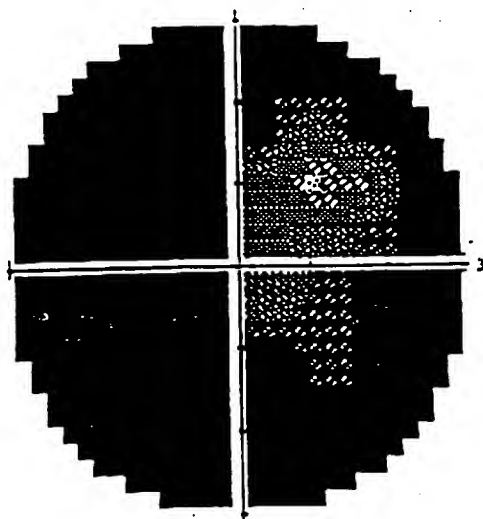
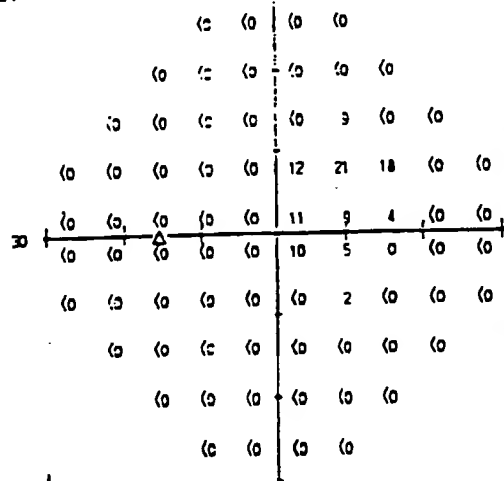
Age: 65

False POS Errors: 0 %

False NEG Errors: 99 %

Test Duration: 06:27

Fovea: 19 dB ■



-25	-25	-25	-25
-27	-28	-28	-28
-28	-29	-30	-31
-29	-30	-31	-32
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-32	-33	-34	-35
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036/195-39-54 3 07/27/00
SMITH, PATRICK
M 66 06/20/1934 SML

VN# 3022

UCLA MEDICAL CENTER
**LEAVING HOSPITAL
AGAINST MEDICAL ADVICE**

INSTRUCTIONS: Complete all blanks. Strike words that do not apply. The physician completes the "Advice" section. The patient signs the "Release" section.

Patrick Smith
PATIENT'S NAME

PERSON BEING ADVISED

PHYSICIAN ADVISING

FAX RECEIVED

Care being refused (specify and describe):

CT Scan head,
Syncope work up.

FEB 13 2001

PETITIONS OFFICE

Risks/complications that can/will result from refusal of the above described advised care (specify and describe):
Include: Loss of Death, Irreversible brain injury

I certify that, to the best of my belief, the patient understands the risks of refusing care.

SIGNATURE OF PHYSICIAN ADVISING PATIENT/RESPONSIBLE PARTY

7/27/00
DATE AND TIME OF ADVICE

☐ AM ☐ PM

SIGNATURE OF TRANSLATOR (IF APPLICABLE)

I, Patrick Smith acknowledge that on 7/27/00
Dr. Talhar advised me of the above stated risks and/or complication which could or would arise from refusal of the above advised medical care. I understand the risks and/or complication. It is still my desire to refuse the advised medical care stated above.

I do hereby release UCLA Medical Center, its agents, employees and physicians from all liability resulting from an adverse medical condition(s) caused by my refusal of the above advised medical care.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

SIGNATURE OF TRANSLATOR (IF APPLICABLE)

DATE AND TIME

☐ AM ☐ PM

On _____, this patient/responsible party _____

- ☐ refused the above stated advised medical care.
☐ left UCLA Medical Center without signing the above release.
☐ left UCLA Medical Center without full medical advice.

M.D./R.N. SIGNATURE

7/27/00
DATE AND TIME

☐ AM ☒ PM

Refer to N.S. Policy No. 202

Best Available Copy

☐ FRIEND ☐ POLICE ☐ PARAMEDICS ☐ OTHER

DISCUSSED WITH PMD:

036/195-39-54 3

07/27/00

SMITH, PATRICK

M 66 06/20/1934

SML

CONSULT PAGED:

@:

@:

☐ TRANSLATOR REQUIRED☐ RN ASSESSMENT REVIEWED

EMERGENCY STRIP:

CT/UTZ:

VN# 3022

RUA:

PREGNANCY:

ABG:

PT:

INR:

PTT:

CK:

MB:

TROPONIN:

Ca:

Mg:

Phos:

AST/ALT:

Alk Phos:

T. Bil:

X-RAYS:

ECG:

OTHER:

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PETITIONS OFFICE

☐ NO SIGNIFICANT CHANGE SINCE:

☐ PRIOR ECG REVIEWED, ☐ OTHER:
☐ PRIOR LABS REVIEWED WHICH SHOWED:☐ PRIOR MED RECORDS REVIEWED WHICH SHOWED:

LACERATIONS

LENGTH	LOCATION	<input type="checkbox"/> SIMPLE <input type="checkbox"/> LOCAL <input type="checkbox"/> CMPLX <input type="checkbox"/> DIGITAL BLOCK	DISTAL ROM <input type="checkbox"/> WNL	DISTAL SENSORY <input type="checkbox"/> WNL	DISTAL CIRCULATION <input type="checkbox"/> WNL	TENDONS <input type="checkbox"/> WNL	SUTURE TYPE	PREPARATION <input type="checkbox"/> IRRIGATION	ANESTHESIA <input type="checkbox"/> LIDO _____ %
LENGTH CM	LOCATION	<input type="checkbox"/> SIMPLE <input type="checkbox"/> LOCAL <input type="checkbox"/> CMPLX <input type="checkbox"/> DIGITAL BLOCK	<input type="checkbox"/> WNL	<input type="checkbox"/> WNL	<input type="checkbox"/> WNL	<input type="checkbox"/> WNL		<input type="checkbox"/> IRRIGATION	<input type="checkbox"/> LIDO _____ %

☐ I was present with Dr. _____

during the key portion of the

procedure performed.

☐ See procedure note☐ Laceration repair☐ Endotracheal intubation ☐ RSI☐ Conscious sedation☐ LP ☐ Central line☐ Other _____☐ I was personally present and supervised the entire

performed by Dr. _____ procedure

EMERGENCY DEPARTMENT COURSE AND DECISION MAKING - RE-EVALUATIONS AND DIFFERENTIAL DIAGNOSIS

23:18 Woke to have AAA - don't want
notes w/u. Edo starting AAA.
Island

ATTENDING NOTE: I have examined the patient and agree with the findings
and treatment plan of Dr. TARKAN

DISCHARGE IMPRESSION:

1. Syncopal

2.

3.

4.

DISCHARGE PLAN:

1. PT, Left Arm.

2.

3.

4.

CONDITION ON DISCHARGE

☐ GOOD ☐ AMBULATORY ☐ HOME ☐ ADMIT ☐ EXPIRED
☐ FAIR ☐ WHEELCHAIR ☐ LEFT WITHOUT BEING SEEN
☐ CRITICAL ☐ CRUTCHES ☐ LEFT AGAINST MEDICAL ADVICE

☐ STABLE FOR TRANSFER TO _____ ☐ EMT ☐ PARAMEDIC ACCEPTANCE NO.:

☐ CRITICAL CARE TIME: MINS.☐ COMPLETE CHART☐ SIGNED OUT TO:

TIME:

SIGNATURE #1

MD

SIGNATURE #2

MD

ATTENDING SIGNATURE

SEE NOTE

PRINT NAME

PRINT NAME

PRINT NAME

MD

DICTATED

☐

Eyes Examined • Contacts • Glasses
Emergency Service

10724 Washington Blvd.
Culver City, CA 90230

(213) 870-2848
(310) 559-0500
FAX (310) 559-4009

3/17/00

re Smith, Patrick
2/20/34

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Visual Acuity OS (left eye) today is
20/200+, best corrected. Pin hole
visual acuity gives minimal improvement
to 2/100-4/4. Based on patient provided
form, this is a 25% reduction

Smith

M. J. W.

2.1- VISION

LOSS OF SIGHT WITH COSMETIC EFFECT

Enucleation (or evisceration) of one eye:

2.121 With ability to wear artificial eye 30%
2.131 With inability to wear artificial eye 35%

Loss of sight of one eye⁵

2.141 With marked blemish that would afford
an observer evidence of the loss 30%

LOSS OF SIGHT

2.211 Loss of sight of one eye with no blemish
that would afford an observer evidence of
the loss 25%
2.213 Loss of both eyes or the sight thereof 100%

2.3 REDUCTION OF VISION⁶

2.311 Reduction of vision, one eye to:⁷

Distance (Snellen) as index	Near (Jaeger) as index	
20/20	1, 2, 3, 4	0%
20/30	5	3%
20/40 .....	.....	5%
20/50 .....	.....	7%
20/60 .....	.....	9%
20/70 .....	.....	11%
20/80 .....	.....	13%
20/100	6	16%
20/125	7, 8	19%
20/160 .....	.....	22%
20/200	9	25%

2.313 Reduction of vision of both eyes⁸

2.4 APHAKIA (LOSS OF NATURAL LENS)⁹

One eye, correction of visual acuity with
spectacle lens to:

2.411	20/25 or better	20%
2.421	20/30 to better than 20/50	21%

⁶ Ratings are based on vision with best practicable correction.

⁷ When reduction of distance and near vision are both present, use index which produces the higher standard rating.

⁸ To obtain rating for bilateral reduction of vision, see Table 1C "Eyes - Bilateral Reduction of Vision", on page 7-3.

⁹ In cases of aphakia with practicable correction by means other than spectacle lens, the standard rating shall be based on disability found under reduction of vision (disability 2.3) plus 1/2 the difference between disabilities 2.4 and 2.3.

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⁴ Consideration may be given to such factors as: ptosis of eyelid, entropion (turning in of the lid), ectropion (turning out of the lid), lacrimation, photophobia, chronic conjunctivitis, enlarged pupil, coloboma (irregular pupil), blurring, scarring of the eyeball.

⁵ In case of loss of sight with blemish, the standard will vary between the ratings for disabilities 2.141 and 2.211, depending on the degree of the disfigurement.

859-0290

ALI A. KASHANI, M.D.
DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY
436 NOTRH ROXBURY DRIVE SUITE 114
BEVERLY HILLS, CALIFORNIA 90210
U.S.A

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FEB 13 2001

PETITIONS OFFICE

ember 14, 1999

Mr. Smith Patrick

Whom It May Concern:

se be advised that Mr. Patrick Smith was seen at our office for his eye condition and he paid 0.00 for today's visit. He needs to have three more follow up visits with me, and a visual test. Mr. Smith needs to pay \$600 for the follow up visits and required tests. Mr. Smith has been seen at Cedars-Sinai Hospital before, and he was reportedly diagnosed with left anterior chamber hemorrhage. His eye pressure is normal right now but he needs follow up. He may also require B-scan.

Thank you for your attention. Please do not hesitate to call us if you have any questions.

Sincerely Yours,


A. Kashani, M.D.

STEPHEN B. FIERSTIEN, M.D.

A PROFESSIONAL CORPORATION

BEVERLY HILLS IMAGING MEDICAL CENTER

145 SOUTH DOHENY DRIVE

BEVERLY HILLS, CALIFORNIA 90211

TELEPHONE (310) 550-5858

FAX (310) 550-5771

DIAGNOSTIC RADIOLOGY

January 5, 2000

Dear Mr. Smith,

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PETITIONS OFFICE

Dr. Ali Kashani has asked our office to schedule you for an MRI Brain scan and an MRI Orbit scan. I understand that there are financial reasons that would prevent you from having these necessary exams. I have agreed, at Dr. Kashani's request, to accept a cash payment of \$1,500.00 dollars, paid at the time of service, as payment in full. I hope we can be of service to you.

Sincerely,

Paula Nickolas

Paula Nickolas
Office Manager

U C L A H E A L T H C A R E
UCLA MEDICAL CENTER
PATIENT STATEMENT OF ACCOUNT - DETAIL

PAGE
09/01/00 15:3

PATIENT NAME: SMITH, PATRICK

ACCOUNT NBR: 000073088-3022
BILLING PERIOD: 07/29/00 09/01/00

BILL TO
PATRICK SMITH
2901 BEVERLY BLVD
LOS ANGELES CA 90057

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SRV DATE	REF NBR	DESCRIPTION	
07/27/00	15400023	CHLORIDE, SERUM	33.00
07/27/00	15400029	CO2 CONTENT, SERUM	33.00
07/27/00	15400031	CREATININE	33.00
07/27/00	15400042	GLUCOSE	33.00
07/27/00	15400072	POTASSIUM	33.00
07/27/00	15400079	SODIUM	33.00
07/27/00	15400086	UREA NITROGEN	59.00
07/27/00	15400266	CBC & PLT & DIFF	36.00
07/27/00	15400380	PT	49.20
07/27/00	15400353	APTT	243.00
07/27/00	28900027	ER LEVEL IV	8.00
07/27/00	28900631	ELECTRODES	142.00
07/27/00	28900193	INTRAVENOUS STARTS	
-- WE HAVE BILLED THE FOLLOWING INSURANCE(S) --			
07/29/00 - 08/31/00			
MEDI-CAL			

REMIT TO
UCLA HEALTHCARE
10920 WILSHIRE BLVD
SUITE 1600
LOS ANGELES

CA 90024

BEGINNING BALANCE
NEW CHARGES/ADJUSTMENTS
NEW PAYMENTS/CREDITS
CURRENT ACCOUNT BALANCE

0.00
768.20
0.00
768.20

MAKE CHECK PAYABLE TO: UCLA HEALTHCARE

IF YOU HAVE ANY QUESTIONS CONCERNING THIS STATEMENT PLEASE CONTACT:
CUSTOMER SERVICE PHONE: (310) 825-8021

All labs, EKGs, plain x-rays, oxygen saturations and rhythm strips are interpreted by the ED physician unless otherwise specified

Pulse Ox: SO2 Laboratory and radiographic results:

Rhythm strip: Rate 77 NSR AB SVT

Occasional / frequent PACs / PVCs

Sinus bradycardia / tachycardia Other

EKG: Rate 75 NSR AB SVT

Sinus bradycardia / tachycardia AB SVT

Vtach LBBB RBBB LAFB Q's LVH

NSSTT's PRWP Occasional / frequent PACs / PVCs

ST elevation mm Leads

ST depression mm Leads

Dx: Normal EKG Borderline EKG Abnormal EKG

CXR: Normal size CM CHF Infiltrate

Dx: Normal CXR Borderline CXR Abnormal CXR

ED course: ☐ Reassessments ☐ Consultations ☐ Procedure note ☐ Prior records reviewed

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☐ Admitted to ED observation [DATE/TIME]] EDMD Observation note (Re-exam required) Dx:

Procedures: Central line Chest tube CPR ET intubation FB removal Nerve block I&D LP Still lamp exam Restraints Other

☐ Laceration repair: Length cm

☐ Fracture(Fx)/Dislocation(D) care:

☐ Conscious Sedation: Reason:

Simple / Complex Anesthesia

Bone Fx / D

Sedation/Analgesic agent(s)

☐ Irrigated w/NS Suture

Fx: Displaced / Nondisplaced

Post-procedure evaluation: [TIME]

Type Number

☐ Initial treatment and stabilization

☐ Awake, alert, ambulatory ☐ Vital signs stable

☐ Treatment: Application of Sling / Splint

☐ Conscious sedation protocol followed-see nursing record

Clinical Impression: 1) ACUTE DIZZINESS

2) GASTROESOPHAGEAL REFLUX DISEASE

3) _____

4) _____

5) _____

Disposition: ☒ Home ☐ Left AMA Admitted by Dr. _____ To _____

Transferred to _____ By _____ No. _____ Accepted by Dr. _____

☐ Stable for transfer ☐ Unstable for transfer ☐ Transferred to a higher level of care

Condition on disposition or transfer: ☒ Stable ☐ Unstable ☐ Expired

CRITICAL CARE TIME _____ minutes

ED PA/MD Discussed with Dr. _____ Signed out to Dr. _____

History and physical exam performed and clinical decisions made by Dr. _____

1) Ala Deje

ACI: Abdominal pain Ankle sprain Asthma

Back pain Chest pain Diarrhea Fever Headache

Head injury UTI Viral syndrome Vomiting Wound

Wound / _____ days Suture removal _____ days

Follow up in _____ with _____

Do not drive while taking _____

☒ RTED or PMD for a worsening of symptoms

☒ Instructions explained & questions answered

☐ Left AMA ☐ Risks explained ☐ Pt competent

F/U AT UCLA-NERD

FORGROW
AS SCHEDULED

ADDRESSOGRAPH



Saint John's Health Center

Santa Monica, CA 90404

SMITH, PATRICK

MO203156 L015772940

HEILPERN, ALAN M.

06/20/01

EMERGENCY DEPARTMENT SUMMARY

03/06/00 N 56

REC 18

Best Available Copy



REPORT OF VISION EXAMINATION

(Form valid for 6 months from examination date)

91

APPLICANT COMPLETES THIS SECTION

DRIVER LICENSE NUMBER P0440873	DATE OF BIRTH (MO., DAY, YR.) 6-20-34	HOME TELEPHONE NUMBER
NAME (FIRST, MIDDLE, LAST) Patrick Smith		
RESIDENCE ADDRESS 2901 Beverly Blvd.	CITY Los Angeles	STATE Cal.
EXPIRATION DATE 2-3-00		FIELD OFFICE Santa Monica
APPLICANT'S SIGNATURE		DATE FEB 13 2001

authorize the vision specialist conducting this examination to provide the Department of Motor Vehicles (DMV) with the following information for its confidential use (CVC1808.5) in evaluating my ability to safely operate a motor vehicle.

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OPHTHALMOLOGIST OR OPTOMETRIST COMPLETES THIS SECTION

REFRACTION		DEFINITIONS OFFICE
HAVE NEW DISTANCE LENSES BEEN PRESCRIBED AND FITTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Bioptic Telescope		DATE NEW LENSES WERE PRESCRIBED 2-9-2000
DISTANCE LENSES WERE PRESCRIBED AND FITTED, IS THIS THE BEST POSSIBLE CORRECTION? IF NO, EXPLAIN. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No History of recent Trauma C.E. requires Evaluation		
A BIOPTIC TELESCOPIC LENS WAS PRESCRIBED, IS IT <input type="checkbox"/> Galilean <input type="checkbox"/> Keplerian <input type="checkbox"/> Periscope/Keplerian <input type="checkbox"/> Other		
DID YOUR PATIENT RECEIVE TRAINING IN USING THE BIOPTIC TELESCOPIC LENS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, WAS DRIVING INCLUDED IN THE TRAINING? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

VISUAL ACUITY

DMV MEASUREMENT (ORTHORATER OR EQUIVALENT)

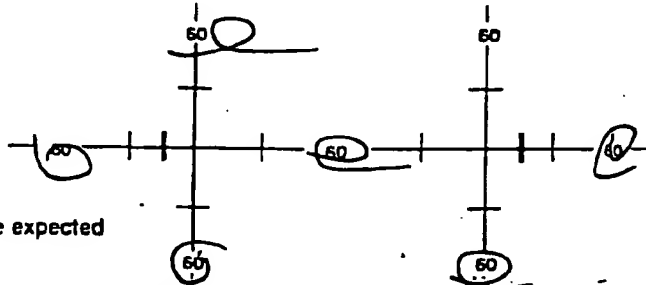
CLINICAL MEASUREMENT

	Both Eyes	Right Eye	Left Eye		Both Eyes	Right Eye	Left Eye
Without Lenses	T/20/40	T/20/40	T/10	Without Lenses	20/50	20/50	20/100
With Lenses	T/	T/	T/	With Correction	20/25	20/25	20/100

VISUAL FIELDS A full visual field examination extending at least 60°, using a standard test object such as a 10mm white mark, must be performed if any condition exists which might affect peripheral vision. Show the approximate peripheral extent and any scotomas in the diagram below.

LEFT EYE

Extent: **180°**
 Right: **90°**
 Up: **180°**
 Down: **90°**



RIGHT EYE

Extent: **180°**
 Left: **90°**
 Right: **180°**
 Up: **90°**
 Down: **90°**

☒ No condition exists that would be expected to impair visual fields.
☐ Diagram is attached.

DIAGNOSIS Please indicate the severity of the vision condition by placing a number 1, 2, or 3 in the box representing the affected eye(s) (1 = mild 2 = moderate 3 = severe). Definitions of mild, moderate, and severe for each condition can be obtained from DMV. If your patient has Hemianopia or Pseudophakia, check the box representing the affected eye.

Myopia	R <input type="checkbox"/> L <input type="checkbox"/>	Aphakia	R <input type="checkbox"/> L <input type="checkbox"/>	Astigmatism	R <input type="checkbox"/> L <input type="checkbox"/>	Cataract	R <input type="checkbox"/> L <input type="checkbox"/>	Diplopia	R <input type="checkbox"/> L <input type="checkbox"/>	Glaucoma	R <input type="checkbox"/> L <input type="checkbox"/>
Hyperopia	R <input type="checkbox"/> L <input type="checkbox"/>	Hemianopia	R <input type="checkbox"/> L <input type="checkbox"/>	Keratoconus	R <input type="checkbox"/> L <input type="checkbox"/>	Myopia	R <input type="checkbox"/> L <input type="checkbox"/>	Nystagmus	R <input type="checkbox"/> L <input type="checkbox"/>	Pseudophakia	R <input type="checkbox"/> L <input type="checkbox"/>
Coloma	R <input type="checkbox"/> L <input type="checkbox"/>	Decreased Vision	R <input type="checkbox"/> L <input type="checkbox"/>	Diabetic Retinopathy	R <input type="checkbox"/> L <input type="checkbox"/>	Macular Degeneration	R <input type="checkbox"/> L <input type="checkbox"/>	Retinal Detachment	R <input type="checkbox"/> L <input type="checkbox"/>	Strabismus	R <input type="checkbox"/> L <input type="checkbox"/>

☐ Pigmentosa ☐ monocular ☐ Could the condition in the blind eye affect the fellow eye in the future? ☐ Yes ☒ No

When was the monocular vision diagnosed? **1/3 Regaining Full Work - 6 mos including Scan of C.E.**

Hemianopia: Please identify the quadrants affected on the chart above.

PROGNOSIS

☐ Stable ☐ Potentially progressive ☒ Improvement possible

PLEASE ESTIMATE HOW SOON YOUR PATIENT'S VISION SHOULD BE REEVALUATED. **6 mos**
☒ 6 mos. ☐ 1 year ☐ 2 years ☐ 4 years ☐ Other

ADVICE

HAVE YOU GIVEN YOUR PATIENT ABOUT DRIVING?

☒ Drive in familiar areas only ☐ No night driving ☐ Do not drive ☐ No advice given. ☐ Other

PRINTED NAME Laurie Friedman	SIGNATURE [Signature]	M.D. OR O.D. LICENSE NUMBER 4423	DATE OF EXAM 2-2-00
ADDRESS 10724 Washington Blvd	CITY BLD	ZIP CODE (310) 559 0500	TELEPHONE NUMBER

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